

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=63-020787**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 176

**FILED JUN 4 1963**

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>		Length of stay in 1b <u>8 DAYS</u>	c. CITY OR TOWN <u>MONROE CITY</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SHADY LAWN REST HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ROUTE 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>ALBERT</u> Last <u>FRY</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1963</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 14, 1877</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (RET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>St LOUIS, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>SAMUEL P. FRY</u>		13b. MOTHER'S MAIDEN NAME <u>MADELINE ANDRES</u>		14. NAME OF HUSBAND OR WIFE <u>EUNICE E. FRY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>WEBBER FRY MONROE CITY, MO R.F.D. 1</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral arteriosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	

21. I attended the deceased from <u>2-20-56</u> to <u>5-16-63</u> and last saw him alive on <u>5-16-63</u> Death occurred at <u>8:45 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>100 N. Sixth, Hannibal, Mo.</u>	22c. DATE SIGNED <u>5-17-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 18, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St STEPHENS CEMETERY</u>	23d. LOCATION (City, town, or county) <u>MONROE CITY, Mo Route 1</u>
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24. FUNERAL DIRECTOR <u>Wilson &amp; Sons</u>	25. DATE RECD. BY LOCAL REG. <u>May 17, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luske by Lillian M. Herman</u>
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Licensed Embalmer's Statement on Reverse Side

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

VS 300  
Rev. 4/59

1 0648

2 0690

3

4 0

5 1

6

7 0

8 0

9 420.1

10

11

12 86-0

13 1-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by Me Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Leslie T. Hilary*

Licensed Embalmer No. 3014

P. O. Address Monroe City, MISSOURI

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

2430

0930

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0-33

Correct record 5/17/63